Policy for
RESIDENTIAL PLACEMENTS

For Children and Adolescents in Need of
Residential Mental Health Treatment

Vermont Department of Mental Health

**Child, Adolescent and
Family Unit**

April 2008

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Vermont's system of care and the Department of Mental Health (DMH) hold the value that children should live with their families and within their own communities. Research shows that community-based interventions are crucial for a child's and family's long-term success (Haogwood, Burns, Kiser, Ringeisen, and Schoenwald, 2001). The system of care is designed to provide community-based mental health treatment with the goal of supporting a child's progress and success within the context of family and community. Residential treatment is an integral component within Vermont's system of care. There may be times when a child requires a brief out-of-home placement as part of his/her primary community-based treatment plan. Residential interventions are most successful when the child transitions home quickly to a package of community-based supports (Surgeon General's Report, 2001). Any residential placement should be designed to support the child and family so that the child can quickly return to their primary home- and community- based plan.

This policy will discuss how a Designated Agency or Specialized Service Agency (DA/SSA) will:

- Assess clinical eligibility for residential placement.
- Triage children based on clinical acuity.
- Evaluate the progress of all children and continued clinical eligibility.

This policy also provides guidance to DMH for CRC approvals and triage of available resources.

The Surgeon General Report in 2001 states that transferring gains from a residential setting back into the community may be difficult without clear coordination between residential staff and community services, particularly schools, medical care or community clinics. Since a community based plan is the core of a child's plan and residential treatment is a step in reaching that plan it is imperative that the community and the residential program coordinate from the very first step of referral to the discharge. Furthermore the Surgeon General's Report stresses the importance of developing coordinated aftercare services in order to support the skills gained during a residential placement and that can only be accomplished through collaboration between the community team and the residential program.

For some children, short-term, residential placement resources are an important step towards long-term home and community-based success. The local team should explore barriers to home-based supports if an out-of-home placement is required. The ACT 264 process and the Local Interagency Team may be helpful to explore these barriers and to establish a plan for permanency.

Eligibility Criteria

Residential Treatment services, funded through the Department of Mental Health, may be provided only to people who:

- Are resident of Vermont
- Have not yet reached his/her eighteenth birthday
- Have been determined to be eligible for Vermont Medicaid
- Is an active client of a designated agency(DA) or specialized services agency (SSA)
- Remain in the custody of his/her parent(s) or guardian(s)
- Has a diagnosed mental illness as defined by the current DSM codes. (The diagnosis must have been made by a psychiatrist within the last six months, and the child must currently be receiving treatment for this diagnosis. The diagnosis is the main contributing factor to the child's inability to access community-based services.)
- Conduct disorder, pervasive developmental disorder, substance abuse, or mental retardation without a co-occurring mental illness diagnosis is not sufficient to meet the diagnostic criteria.

Exclusions:

By themselves, the following situations do not justify residential care:

- The client's behavior profile is marked by disturbance of conduct and/or delinquency exclusive of a mental illness.
- Admission is primarily an attempt to prevent, or to serve in lieu of, incarceration or detention.
- Admission is essentially for custodial or placement care.
- The primary function of admission is respite.
- The client and/or family consistently refuse treatment.
- Admission is primarily for the purpose of removing a person from an undesirable environment. This includes situations involving abuse or neglect within the home or substance abuse within the home, for example.
- Admission is primarily a result of unmanageability within the home or community.
- Admission is primarily a result of unavailable parenting.
- Admission is primarily a substitute for less intensive levels of care which would be sufficient.
- Conduct disorder, pervasive developmental disorder, substance abuse, or mental retardation without a co-occurring mental illness diagnosis is not sufficient to meet the diagnostic criteria.

Admissions Criteria

Documented evidence contained within the Coordinated Service Plan, recent clinical assessments and/or clinical notes demonstrate the following:

1. The child must have an eligible diagnosed mental illness that can be documented through the assignment of appropriate current DSM codes, and the Child Behavior Checklist (CBCL) total score has been in clinical range within the last 3 months **and,**
2. The child is a danger to self/others or is at risk of becoming a danger due to mental illness **and,**
3. The child cannot be managed in the community, as evidenced by recent failures in the community or by a history of unmanageability in the community **and,**
4. The family must have a history of active participation in treatment, including in-home supports. The expectation is that the family will be actively involved in treatment or, with appropriate supports, would be able to participate in treatment. The members of the family are able to recognize their role in treatment and are willing to explore ways to improve their functioning **furthermore,**
5. The treatment plan must include a detailed description of how the parent(s)/guardian(s) will remain actively involved in treatment and the parent(s)/guardian(s) must be willing to continue active participation in treatment upon the child's admission to a residential facility **and,**
6. The local treatment team must have clearly defined clinical goals that include family involvement. These clinical goals must be consistent with the level of expertise of the residential facility **and,**
7. The local treatment team must have a clearly defined method to gauge progress and assess outcomes. How the team knows when the child and family have achieved their clinical goals must be clearly defined **and,**
8. The plan must include a detailed description of how the child is to be reintegrated back into his/her home and community **and,**
9. The client and/or family is consistently willing to engage in treatment. The child's engagement and/or resistance to engage in treatment is developmentally appropriate.

Continued Stay Criteria

Documented evidence that:

1. The eligible diagnosis remains the primary reason the client continues in residential treatment. The diagnosis continues to be the focus of treatment within this level of care and/or a community plan continues to be unavailable and clinically determined to be ineffective and/or the focus of the treatment continues to be stabilization/alleviation of symptoms. The client continues to exhibit clinical-range behaviors as documented by CBCL.
2. Based on clinical judgment the client is a danger to self/others or is at risk of becoming a danger shortly after discharge.
3. The comprehensive discharge plan is formulated and reviewed regularly and includes specific target dates for implementation; and the DA continues to be involved in continuity of care, including discharge planning within the approved length of stay timeframe.
4. The psychiatric symptoms continue to show objective improvement and are not yet stabilized.
5. The family or guardian continues to be actively involved in the treatment process. The goal is to return to family and, if not, other partners need to be active in the process so that permanency planning is commenced.
6. The client and family continue to be invested and actively involved in the treatment process and agree with the treatment plan.
7. The local DA staff continues to participate in treatment planning, meetings and the entire process to ensure this portion of a child's plan is meeting the child's treatment needs.
8. The local treatment team (which includes DA staff, education, parents and other community partners) has not yet been able to establish comprehensive services to maintain the child in the community as evidenced by one or more of the following circumstances:
    - the treatment team lacks some necessary services or,
    - these services may be of inadequate quality or,
    - the placement may be notably ambivalent about maintaining the child in the community or,
    - the treatment team has no capacity to work with placement to implement comprehensive services.

    Therefore the local treatment team will need to identify and develop a plan address these barriers in order to create the appropriate community plan.

Funding Priorities for Residential Placements

- **Severity of mental illness** – Highest level of severity/acuity will receive priority for funding.

- **Safety** –As a result of mental illness, the client is unable to maintain an adequate level of safety for self or others across multiple settings including home, school and community. (Schaefer and Swanson, 1988)

- **Active family involvement** – The family and/or primary caregivers are actively participating in treatment both for the child as an individual and the family. The family attends regular treatment team meetings, participates in parent education concerning the mental illness and otherwise contributes to the overall plan.

- **Referrals** – In-state placement in a recognized Private Non-Medical Institution facility will be utilized over an out-of-state placement.

- **Equitable Distribution** – All above variables being the same, funding priorities will be distributed equally throughout the state.

Elements of Residential Programs

Residential programs endorsed by DMH for children and adolescents will have at a minimum the following qualities and will be considered as priority programs:

Comprehensive evaluation – The ability for the facility to provide comprehensive mental health evaluations that enable the treatment team to determine the following:

- Clarification of diagnosis
- Appropriateness and effectiveness of medication
- Appropriate treatment planning and goals
- Progress

Active family involvement – The family is included in the planning and treatment for the individual child. The facility respects and supports the family to engage in the treatment and offers appropriate psycho-education opportunities. It is essential for the family to attend meetings and treatment sessions and to have family visits. It is essential that the family be included as an important contributor to the progress their child makes. It is also important for the child to understand that his/her parents have the responsibility to acquire skills to help him/her as they learn new behaviors in order to reduce any feelings of guilt that may have exacerbated acting-out behavior (Schaefer and Swanson, 1988).

Mental health treatment as primary focus – The primary focus of the placement is to treat the mental health issues that are contributing to the child's inability to function fully in the community, home and school. The identified mental health issues are the focus of the treatment plan, with additional goals as needed. The treatment plan clearly identifies the goals and objectives to alleviate the specific symptoms and impairments that resulted in the admission. It is also important that a systems approach be used; that is, the child's behavior is not treated as "the problem," but the way the family system functions is the focus of treatment along with the child's specific mental health treatment needs (Schaefer and Swanson, 1988).

Progress and outcomes – The facility is able to measure positive outcomes and incorporates tools to gauge progress. The progress is evidenced by a measurable reduction in symptoms and/or behaviors to the degree that indicates continued responsiveness to the treatment (American Academy of Child and Adolescent Psychiatry, 1996). The facility must have

a consistent history of positive outcomes for clients following the treatment they provide.

Treatment plans - The facility will conduct regular treatment team meetings that will update and change plans based on progress and barriers to treatment. Treatment goals will be realistic and achievable and directed towards re-stabilization to allow treatment to continue, matching the child's needs with community capacity. (American Academy of Child and Adolescent Psychiatry, 1996).

Best practices – The facility is using best practices including evidence-based treatments when available, to address child and family needs. The values of the system of care are incorporated. The staff is trained in the values of the system of care, best practices and evidence-based treatment, and makes these a primary focus of their program.

Structured milieu – The milieu offers the child positive peer interaction consistent with diagnosis and clinical goals within the structured environment.

Active involvement of DA – The DA is supported to collaborate and participates actively in the treatment. The DA will be receiving the child back into the community and must be actively involved in both ongoing treatment plans and discharge/community plans. Discharge planning should begin at the time of referral.

Level of staff training and credentials – The staff or contracted staff includes a licensed psychiatrist and licensed mental health clinicians. The staff are credentialed and have training and expertise in treating children with mental health issues.

Additional training - The staff are trained in basic care, first aid, universal precautions, de-escalation and management of aggressive behavior and ongoing improvements in skills needed for best practices.

Confidentiality – The staff maintains confidentiality and obtains releases from parents in order to clarify whom they need to speak with to address treatment needs. The facility operates in compliance with all HIPAA requirements.

Education – A child will receive a *free and appropriate public education* while attending the facility. The facility can provide or has access to special educational services to maintain a child's Individualized Educational Plan while in the program. The educational component of the program maintains

a connection to the sending school and works with that school to establish an educational discharge plan in conjunction with the treatment discharge plan.

Coordination between residential treatment/community treatment and overall treatment plan – There is a clear individualized mental health and family treatment plan that builds on what has been accomplished in the community and what will continue to be developed in the community to support the child and family once the child returns. Short-term and long-term goals are clearly connected and build on each other. The object should be to treat the family as a unit. From the outset the work should be to change and influence the family system rather than just treat the child (Schaefer and Swanson, 1988). There is not an expectation of a child improving in isolation but, rather, a child and family building skills that complement each other and allow for the child's successful reintegration into the family unit. The community is aware of what the residential program is working to accomplish and the residential program is aware of what the community will offer. There is clear communication among all parties in establishing, refining and accomplishing goals. Each entity recognizes the other's part in the overall plan.

Discharge plan – An initial discharge plan is part of the referral to residential placement prior to admission and is reviewed prior to accepting the child in placement. The initial discharge plan is a joint effort by the DA and residential program, and it establishes a direct link to the behaviors and/or symptoms that resulted in the admission. The plan receives regular review and revision, including an appropriate and timely evaluation of post-residential treatment needs. An appropriate and realistic place of post-discharge residence is tentatively designated upon admission, and the child is actively involved in making the choice when appropriate. The main question in developing a discharge plan is "what are we preparing the child for?"

Certification – Department for Children and Families (DCF) license required and national certification preferred.

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This document was created by the Vermont Department of Mental Health, Children, Adolescent and Family Unit, Operations Unit - October 2005